Health Risk Assessment

Name Date Chart#

Provider Signature Provider ID

General Health

I feel good about my health	☐ Yes	☐ No
I smoke tobacco	☐ Yes	☐ No
I use recreational drugs and/or marijuana	☐ Yes	☐ No
I drink alcohol	☐ Yes	☐ No
I visit my dentist for regular checkups	☐ Yes	☐ No

Diet/Nutrition

How do you rate your Nutrition?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

I eat at least 5 servings (1serving = ½ cup) of fruits and vegetables every day

☐ Yes ☐ No

I eat fast food restaurants less than 3 times per week

☐ Yes ☐ No

Physical Activity/Energy

Do you exercise? ☐ Yes ☐ No

How many days in a week do you exercise? _____

What type of exercise do you do? _____

Do you have a normal energy level? ☐ Yes ☐ No

Do you have a low energy level? ☐ Yes ☐ No

Life Satisfaction and Social Connection (Select One)

- ☐ Mostly satisfied with life
- ☐ Feel connected to family and friends
- ☐ Mostly dissatisfied with life
- ☐ Feel disconnected from family and friends
- ☐ Decline to answer

Stress

In the last two weeks, how often have you been bothered by the following:

I am stressed over health, finances, relationships, or work:

☐ Never/Almost Never	☐ Occasionally	☐ Often	☐ Very Often	☐ Always/Almost Always

I feel I have family and/or friends that I can confide in to help me manage my stress:

☐ Never/Almost Never	☐ Occasionally	☐ Often	☐ Very Often	☐ Always/Almost Always

The level of stress in my work environment is manageable for me:

☐ Never/Almost Never	☐ Occasionally	☐ Often	☐ Very Often	☐ Always/Almost Always

I am satisfied with the balance between my work time and leisure time:

☐ Never/Almost Never	☐ Occasionally	☐ Often	☐ Very Often	☐ Always/Almost Always

Concentration & Memory

How would you or your family best describe your concentration and memory?

- ☐ No difficulty concentrating or memory lapses
- ☐ Some difficulty concentrating or memory lapses
- ☐ Significant difficulty concentrating or memory lapses
- ☐ Decline to answer

Safety

In the past year, have you fallen?	☐ Yes	☐ No
Are you afraid of falling?	☐ Yes	☐ No

Motor Vehicle Safety (Select One)

- ☐ I wear a seatbelt when driving or riding in a car
- ☐ I do not wear a seatbelt
- ☐ Decline to answer

Oral Health (Select One)

- ☐ I have problems with my teeth or dentures
- ☐ I have no problems with teeth or dentures
- ☐ Decline to answer

Hearing

Do you struggle with hearing? (Select One)

- ☐ No difficulty hearing
- ☐ Have hearing loss
- ☐ Decline to answer

Assistive Devices

Do you use any devices? (CHECK ALL THAT APPLY)

☐ Cane	☐ Walker
☐ Wheelchair	☐ Crutches
☐ None of the above	

Activities of Daily Living

Do you need help with any of the following? (CHECK ALL THAT APPLY)

☐ Bathing	☐ Controlling urine or bowels
☐ Getting dressed	☐ Eating
☐ Getting up from a chair or bed	☐ Grooming
☐ Using the toilet	☐ I do not need help
☐ Decline to answer	

Instrumental Activities of Daily Living

Do you need help with any of the following? (CHECK ALL THAT APPLY)

☐ Housework/Laundry	☐ Grocery shopping
☐ Managing money	☐ Managing medications
☐ Using the phone	☐ Driving or using transportation
☐ None – I do not need help	☐ Decline to answer

Medication Adherence

Do you have any problems paying for or taking your medications:

- ☐ No problems taking medications
- ☐ Yes, I find it difficult to remember to take my meds
- ☐ Yes, cost is the primary problem
- ☐ Yes, side effects are the primary problem
- ☐ Yes, but for other reasons

Advance Directives

Would you like to learn more about how to plan for future decisions around your medical care?

- ☐ I would like to learn more about advance directives today
- ☐ I am not interested in learning more about advance directives today